New Patient Form

UTZ COSMETIC AND FAMILY DENTISTRY

197 Norwich-New London Tpke.
Uncasville, CT 06382
Phone: 860-848-2470
www.myuncasvilledentist.com

First Name: Last Name: Middle Initial:

Patient is: ❍ Policy Holder ❍ Responsible Party Preferred Name:

Whom May We Thank For Referring You?

Other Immediate Family Members in Our Practice?

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via email.

Birth Date: Age: Social Security:

Sex: ❍ Male ❍ Female Marital Status: ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Employment Status: ❍ Full ❍ Part ❍ Retired ❍ Student (Full / Part) School Name: City: St:

Employer: Address: Occupation: Years:

Emergency Contact: Relationship: Phone: Alt. Phone:

Dentist: Date of last dental visit:

Responsible Party
(if someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security:

❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security: Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Phone: Plan Effective Date:

Group, Plan or Policy #:

Rem. Benefits: Rem Deductible:

Secondary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security: Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Phone: Plan Effective Date:

Group, Plan or Policy #:

Rem. Benefits: Rem Deductible: